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HOUSE BILL 3050
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AN ACT to amend Tennessee Code Annotated, Title 56, relative to credentialing and contracting of healthcare providers by health insurance entities.

WHEREAS, newly licensed physicians, and physicians who move into a new community, often must wait months for a credentialing application to be reviewed and approved by a health insurance entity followed by a contract between the provider and health insurance entity that must be offered, negotiated and signed in order for the provider to be considered as an in-network provider; and

WHEREAS, in this interim period of time, patients may not be able to access health care services because the provider is not considered an in-network provider; and

WHEREAS, the provider who delivers health care services to a patient whose health insurance entity does not compensate the provider for such services while waiting for this process to be finalized will be forced to either bill the patient as a private pay patient, bill the carrier as an out-of-network provider or provide the services at no charge; and

WHEREAS, the federal centers for Medicare and Medicaid services requires an involved credentialing process and reimburses Medicare and Medicaid providers, only after they have been approved as a participating provider, retroactively back to the date of the provider's completed credentialing application;

WHEREAS, an overwhelming percentage of credentialing applications submitted by providers are approved by health insurance entities;

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Title 56, Chapter 7, Part 1, is amended by inserting the following as a new, appropriately designated section thereto:

56-7-1.

(a) A health insurance entity shall reimburse a health care provider as an in-network provider for health care services delivered back to the date of receipt of a completed credentialing application if the health insurance entity ultimately approves the provider's credentialing application and a provider contract is subsequently signed.

(b) Should the health care provider who has applied to become an in-network provider of a health insurance entity choose to hold the claims until such time as the provider has been approved as an in-network provider, then the standard provisions of the entity's contract dealing with timely filing and the provisions of §56-7-109 shall take effect on the date the provider contract was signed rather than the date of service.

(c) Pursuant to subsection (b) above, it is incumbent upon the health care provider to explain to the patient, before the service is delivered, the provider's existing relationship with the patient's primary health insurance entity and that, should the health care provider be denied credentialing or a contract not be signed to become an in-network provider, the patient may be billed and be responsible for paying for some or all of the charges of the service provided.

(d) The health care provider who chooses to hold claims until a contract is signed shall be responsible for receiving a prior authorization for any procedure or service normally required by the health insurance entity in order to be reimbursed as an in-network provider.

(e) The health care provider who held claims and ultimately is not credentialed by the health insurance entity or does not ultimately get a signed contract with the health insurance entity may submit a claim for payment to the health insurance entity as an out-of-network provider. The standard provisions of the entity's contract dealing with timely filing and the provisions of §56-7-109 shall take effect either on the date of receipt of

denial of the credentialing application, the date the provider wrote the health insurance entity that the provider was no longer interested in pursuing a signed contract, or the date of receipt that the provider was turned down in writing for a contract, whichever is later, rather than the date of service.

(f) If the health insurance entity allows reimbursement to out-of-network health care providers, the provider may choose to submit claims to the health insurance entity before a contract is signed. In such circumstances, the provider shall accept as payment in full any reimbursement made as an out-of-network provider and shall not be entitled to resubmit the claim for additional reimbursement if a contract is ultimately signed.

(g) Except where noted elsewhere in this section, all timely filing requirements contained in the contract of the health insurance entity and reimbursements owed to health care providers pursuant to this act shall be made in accordance with §56-7-109.

SECTION 2. The commissioner of commerce and insurance has the authority, if deemed necessary, to promulgate public necessity rules in accordance with the provisions of Tennessee Code Annotated, Title 4, Chapter 5.

SECTION 3. If any provision of this act or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to that end the provisions of this act are declared to be severable.

SECTION 4. This act shall take effect on July 1, 2006, the public welfare requiring it.